Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
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OREGON DIVISION OF FINANCIAL REGULATION BULLETIN DFR 2016-1

TO: All Entities Transacting Insurance in Oregon

RE: Nondiscrimination Related to Transgender Persons in the Transaction of Insurance in Oregon

Bulletin INS 2012-1 issued by the Oregon Insurance Division on December 17, 2012 is withdrawn and replaced with this bulletin, DFR 2016-1.

Purpose:

The purpose of this bulletin is to clarify prohibitions against unfair discrimination in the transaction of insurance in Oregon and to reiterate expectations of the Department of Consumer and Business Services (DCBS) about how insurers and other licensees, and authorized entities must address issues related to transgender persons.

DCBS is committed to ensuring that Oregonians do not face unfair discrimination in accessing any kind of insurance. Although the focus of this bulletin is health insurance, the prohibition against unfair discrimination against transgender persons is equally applicable to other kinds of insurance to the extent necessary to ensure equality of access to coverage, treatment and other insurance services.

DCBS is committed to ensuring that all Oregonians have equal access to all types of insurance and to medically necessary health care benefits, including benefits for the treatment of gender dysphoria.

Authority:

- Federal Laws:
  - The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a (MHPAEA) and implementing regulations at 45 CFR §§146.136 and 147.160
  - The federal Affordable Care Act (ACA), its federal implementing regulations at 42 USC 1186, 45 CFR 156.125(b) and 45 CFR 156.200(e), and related Oregon legislation at ORS 731.097 and 743.822 and rules at OAR 836-053-0008 and 836-053-0009.
  - Patient Protection and Affordable Care Act, section 1557a (42 U.S.C. 18116).

- Oregon Statutory Provisions:
    - ORS 174.100 - Definitions
    - ORS 731.008 - Purpose of Insurance Code
    - ORS 731.016 - Construction of Insurance Code
    - ORS 737.310 - Method of Rate Making
    - ORS 742.005 - Grounds for Disapproval of Policy
    - ORS 743A.168 - Treatment of Chemical Dependency, including alcoholism, and mental or nervous conditions.
    - ORS 746.015 - Discrimination

- DCBS Administrative Rules:
    - OAR 836-010-0155 Gender Specific Contract Language
    - OAR 836-053-0012 - Essential Health Benefits for Plan Years Beginning on and after January 1, 2017
    - OAR 836-053-1404 to 836-053-1409 - Coverage of Mental or Nervous Conditions; Mental Health Parity
    - OAR 836-080-0050 - Authority; Purpose and Scope
    - OAR 836-080-0055 - Unfair Discrimination Identified
    - OAR 836-081-0010 - Unfair Discrimination – Insurance Other than Life or Health Insurance

Background:

Since 2012, the DCBS has prohibited insurers from discriminating on the basis of gender identity or gender dysphoria. In 2014, DCBS amended its rules related to unfair discrimination to specifically prohibit any insurance practices involving distinctions based on sexual orientation that constitute unfair discrimination under ORS 746.015.[1] In 2014, DCBS issued a bulletin related to coverage by health insurers of mental or nervous conditions under Oregon's health parity statutes and amended existing rules and adopted new rules related to mental or nervous conditions (INS Bulletin 2014-1).[2] The bulletin, statutes, and rules discussed in INS Bulletin 2014-1 also apply to gender dysphoria.

Finally, in 2016, DCBS adopted rules establishing requirements for essential health benefits for 2017 and conformed Oregon requirements related to nondiscrimination, gender identity and mental health parity to recent changes in federal regulations and policy relating to mental health parity, nondiscrimination and transgender health care services.[3]

In light of the recent developments and new guidance available, DCBS is withdrawing the prior bulletin (INS 2012-1) and issuing this new bulletin in order to better address the issues related to insurance coverage provided to transgender persons.

[1] OAR 836-080-0050 and OAR 836-080-0055;
[2] ORS 743A.168; OAR 836-053-1404 to 836-053-1409. http://dfr.oregon.gov/public-resources/Documents/bulletins/bulletin2014-01.pdf
[3] OAR 836-010-0155; OAR 836-053-0004; OAR 836-053-0012; OAR 836-053-1404 to -1405.

Explanation of terms used in this bulletin:

The following terms are used in this bulletin. Insurers should consider using these terms in their policies and plans. Many of the definitions are adapted from the California Code of Regulations, specifically 10 CCR 2561.1, and were previously used in Oregon Insurance Division Bulletin INS 2012-1.

"Gender-affirming treatment" (formerly referred to as sex transition surgery or gender transition treatment) means any treatment whose purpose is to bring a person's outward appearance into closer alignment with that person's actual gender identity. This may include mental health treatment as well as medical or surgical procedures, including but not limited to puberty-delaying medications, hormone replacement therapy (formerly referred to as cross hormone therapy), and genital, face and chest reconstructive surgery necessary to change the physical attributes of one's outward appearance to accord with the person's actual gender identity.

"Gender dysphoria" (formerly known as gender identity disorder) is a serious medical and mental health condition characterized by a marked incongruence between one's experienced or expressed gender and assigned gender, of at least six months' duration, as manifested by certain criterion.

"Gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned to the person at birth, a transgender person or neither male or female.

"Gender transition" means the process of changing one's outward appearance, including physical sex characteristics, to accord with the person's actual gender identity. Changing one's outward appearance may include changing one's name or gender-related appearance (such as dress and grooming).

"Sexual orientation" means an individual's actual or perceived heterosexuality, homosexuality, bisexuality or gender identity, regardless of whether the individual's gender identity, appearance, expression or behavior differs from that traditionally associated with the individual's sex at birth.[4]

"Transgender person" is a person who has, or has been diagnosed with gender identity disorder or gender dysphoria, who has received or requires health care services, including counseling related to gender transition, who adopts the dress, appearance, or behavior or who otherwise identifies themselves as a gender different from the gender assigned to that person at birth.

Discussion

Applicability of transgender policy to insurance generally

Although issues related to gender identity most often arise in relation to health insurance, the statutes and rules prohibiting discrimination on the basis of perceived gender or gender identity apply to all types of insurance. Therefore, we first provide a brief discussion of the issue as generally applicable to all insurance. A more detailed discussion of the issue as related to health insurance follows.

[4] ORS 174.100

The Director of DCBS is required to prohibit unfair discrimination in the administration and application of the Insurance Code and to administer and enforce the Insurance Code to protect the insurance-buying public.

Two statutes found in the Insurance Code address unfair discrimination. The first pertains to grounds for disapproval of policy forms:

> **742.005.** The Director of the Department of Consumer and Business Services shall disapprove any form requiring the director's approval:
> (1) If the director finds it does not comply with the law;
> …
> **(4) If the director finds it contains provisions which are unjust, unfair or inequitable;** (Emphasis added.)

The second provision is found in statutes that regulate insurance trade practices:

> **746.015 (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.**

In order to be acceptable, discrimination by an insurer must be based on sound actuarial principles or related to actual or reasonably anticipated experience. If not, the director must conclude that the discrimination is based solely on gender identity or gender dysphoria, which is prohibited just as discrimination based solely on sex or race is prohibited.

The department considers the directives to prevent unfair discrimination in the transaction of insurance to inform its determination of what constitutes unfair discrimination. Although insurers may adopt rates based on statistical evidence of varying risk, the insurer cannot act, either facially or in effect, to discriminate based on race, gender, sexual orientation or any other protected class.

Because the law prohibits an insurer from discriminating on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person, DCBS would necessarily conclude that unfair discrimination exists if an insurer does any of the following:

> (1) Denies, cancels, limits or refuses to issue or renew any insurance policy on the basis of an insured's or prospective insured's actual or perceived gender identity;
> (2) Imposes additional requirements related to a person's gender identity that an insured or prospective insured must meet or comply with in order to obtain an insurance policy;
> (3) Demands or requires a payment or premium that is based in whole or in part on the *insurer's* perceived gender identity of an insured or prospective insured rather than the gender identity of the insured;

Applicability of transgender policy to health insurance

In health insurance, treatment of transgender issues comes up in two areas – as an issue of nondiscrimination and as a mental or nervous condition and how such condition must be handled under the ACA and state and federal mental health parity statutes. The following discussion addresses each area separately.

- Nondiscrimination:

DCBS rules identify sex discrimination, including on the basis of sexual orientation, as unfair to insureds.[5] The 2014 rules use the term "sexual orientation" which should be understood to have the meaning defined in the generally applicable definitions statute, ORS 174.100. There the phrase is defined as "an individual's actual or perceived heterosexuality, homosexuality, bisexuality or gender identity, regardless of whether the individual's gender identity, appearance, expression or behavior differs from that traditionally associated with the individual's sex at birth."

Section 1557(a) of the ACA prohibits discrimination on the basis of sex. The 2016 final federal rules implementing the ACA define discrimination on the basis of sex to include gender identity and sex stereotyping. Sex discrimination is prohibited in any health program receiving federal funds or by an entity established under the ACA, including exchanges. Final regulations have recently been released by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services. Under federal rules, any discrimination on the basis of gender identity or gender dysphoria by an insurer participating on the Oregon Health Insurance Marketplace is prohibited. This law against unfair discrimination prohibits an insurer from denying coverage for any treatment solely on the basis that the treatment is gender-affirming treatment for gender dysphoria.

Essentially, a health insurer may not deny or limit coverage or deny a claim for a medically necessary procedure provided for gender dysphoria on the basis that the procedure or treatment is for gender dysphoria. If the treatment consists of a service provided for the treatment of other conditions or illnesses such as hormone therapy, hysterectomy, mastectomy or vocal training, and the treatment was deemed medically necessary, then the insurer could not deny coverage because in this instance it was for gender-affirming treatment for gender dysphoria.

For example, if an insurer provided coverage for breast reduction surgery to alleviate back pain, the insurer could not deny breast reduction surgery as a gender-affirming treatment so long as the treatment is deemed medically necessary. This places an insured who is seeking coverage of a condition related to gender dysphoria on equal footing with any other person by basing the decision about coverage on medical necessity, not on the person's gender identity or the condition of gender dysphoria. It also assures the insured person equal access to opportunities to challenge an insurer's decision related to coverage, such as mandatory appeal processes. In cases in which coverage is denied because the carrier does not consider it medically necessary, a number of appeals are available to the insured that allow the insured and the insured's provider to demonstrate the treatment is medically necessary. For an individual involved in gender-affirming treatment, the same "medically necessary" decision basis should apply, which would then make available to the individual the same appeal processes as for any claim denial.

[5] OAR 836-0080-0050 and OAR 836-0080-0055.

Like any other medical necessity determination, determination of medical necessity and prior authorization protocols for gender-affirming treatment must be based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field. For example, an insurer may not use a utilization management tool that denies treatment for gender-affirming surgery by categorically failing to recognize any gender-affirming surgery or any specific surgery as an appropriate treatment for gender dysphoria if the medical necessity standard is not developed by medical experts in the transgender health field, or because the insurer fails to even have an appropriate medical necessity standard for gender-affirming treatment.[6] Insurers should always consider current medical evidence in adopting standards for determining medical necessity.

DCBS would conclude that unfair discrimination exists if an insurer does either of the following:

(1) Designates gender dysphoria as a preexisting condition for which coverage will be denied or limited; or

(2) Excludes all treatments for "gender identity disorders," even if that exclusion applies only to a subset of insureds, such as insureds under the age of 18.

Furthermore, any requirements that clients seeking gender-affirming treatment pay extra out-of-pocket costs, or incur expenses related to additional surgical or medical consultations that are not imposed for other conditions are not allowed because these requirements discriminate based on the health condition, gender dysphoria, and would be considered differential treatment which on its face is discrimination. For the same reason, an insurer may not require a rider or extra endorsement to a policy to cover gender-affirming treatment.

The perceived gender or gender identity of a person should not prevent appropriate treatment required by mandates that are gender specific. After 2014, all coverage included in the Essential Health Benefit Plan selected for Oregon is mandated under the provisions of state and federal law. Except for standard metal level plans, and requirements related to the Oregon benchmark plan, the extent of coverage, deductibles and copayments offered by an insurer are not regulated. The exceptions to this are the essential health benefits and coverage required by the statutory mandates codified in ORS Chapter 743A. The mandates set forth in ORS Chapter 743A have been specifically enacted by Oregon's Legislative Assembly to require insurers to include certain coverage in health policies and health benefit plans. These mandates include a variety of conditions or treatments, such as treatment for alcohol and drug addiction (ORS 743A.164, 743A.168), provision of orthotic devices (ORS 743A.144), certain minimum screenings for breast cancer (ORS 743A.108) and prostate screening examinations (ORS 743A.120).

Any health care services that are ordinarily or exclusively available to individuals of one sex may not be denied based on the *perceived* gender or gender identity of a person when the denial

[6] A number of medical professional organizations have addressed the medical necessity of gender-affirming surgery and insurers should look to these and other similar, current standards and recommendation in establishing and making future modifications to medical necessity determinations for gender-affirming treatment. *See,* "Health Care for Transgender Individuals," Committee Opinion of the Committee on Health Care for Underserved Women, The American College of Obstetricians and Gynecologists, December 2011; Resolution #114, American Medical Association House of Delegates, "Removing Barriers to Care for Transgender Patients," Received 04/14/08; "Position Statement on Access to Care for Transgender and Gender Variant Individuals," Official Position of the American Psychiatric Association, approved May 2012; "APA Policy Statement: Transgender, Gender Identity & Gender Expression Nondiscrimination," adopted by the American Psychological Association Council of Representatives, August 2008. *See also,* the Standards of Care, version 7 by the World Professional Association of Transgender Health, reaffirmed by the Endocrine Society and the American Medical Association.

or limitation is due only to the fact that the insured is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender-affirming treatment.

If a treatment is determined to be medically necessary and the coverage is one that is provided under the policy, the gender of the patient is usually irrelevant. However, some Oregon mandates appear to be particular in requiring coverage for either male or female patients. See e.g., ORS 743A.104 (coverage for pelvic and Pap smear examinations required for women annually for women 18 to 64 years of age), ORS 743A.108 (coverage required for physical examinations of breast for women) and ORS 743A.120 (coverage required for biennial prostate screening examinations for men 50 years or older).

Recent federal regulations and a rule adopted by DCBS aligning Oregon law with federal law prohibit limiting preventative services to the perceived gender or gender identity of a person.[7] In light of these regulations and the gender-specific language in these particular statutes, we conclude that although the legislature intended these mandates to only apply to the sex indicated in the mandates, the mandates should not be construed to limit the coverage provided to the perceived gender or gender identity of a person. DCBS will require an insurer to cover any sex-specific mandated coverage, if medically necessary, regardless of whether a person self-identifies as the sex identified in the statute and regardless of the gender recorded by an insurer. In other words, we would view the Pap smear mandate (ORS 743A.104) as applicable to an individual with a cervix regardless of whether their gender identity is female, and we would view the prostate screening mandate (ORS 743A.120) as applicable to an individual with a prostate regardless of whether their gender identity is male.

- Gender dysphoria as a mental or nervous condition:

The mandated coverage for mental health services must include mental health counseling and gender-affirming treatment for gender dysphoria.

Because gender dysphoria is a mental or nervous condition included in the DSM-5 and Oregon defines "mental or nervous condition" as any condition diagnosed under the DSM-5, gender dysphoria falls under the requirements of the state and federal mental health parity statutes. This means that any individual or group health benefit plan in Oregon must provide coverage of gender dysphoria at the same level as treatment is provided for other medical conditions. In 2014, DCBS issued a bulletin, INS 2014-1 clarifying the department's expectations related to mental health parity generally. That bulletin and the advice contained in it are adopted by reference into this bulletin and apply to the treatment of gender dysphoria, which is a mental or nervous condition under the diagnostic criteria of the DSM-5 as defined in OAR 836-053-1404. Some of these requirements are highlighted here.

A health insurer may not categorically exclude coverage for a particular gender-affirming treatment, if the treatment is the only medically necessary treatment available for the person. This includes categorical exclusions such as an exclusion for cosmetic surgery if the treatment is deemed medically necessary for the mental condition of gender dysphoria. Nor may the insurer establish such a broad categorical exclusion or impose utilization controls so there is no viable treatment covered for the insured's condition. This kind of exclusion runs counter to state and federal guidance on mental health parity requirements

[7] *See* OAR 836-010-0155(2).

In most cases, an insurer may exclude a service that is not mandated by legislative action. However, an insurer may not exclude such services solely because the service is provided for the treatment of gender dysphoria.

DCBS expects insurers' forms to comply with the policy regarding coverage of transgender individuals and gender-affirming treatment as it is set forth in this bulletin.

An insurer cannot simply exclude "Gender Identity Disorders" or "Treatment for Gender Identity Disorder" because this constitutes discrimination based on gender identity, a type of sexual orientation discrimination. The insurer may exclude specific procedures that may be used in treating gender dysphoria, but the exclusion must apply to all insureds equally, may not be excluded solely because it is for gender dysphoria, and may not be such a broad categorical exclusion that it leaves the insured with no way to obtain treatment deemed medically necessary.

Director's expectations for insurers and other regulated entities

DCBS is committed to ensuring that Oregonians do not face unfair discrimination in accessing any kind of insurance. For property or casualty insurance, this means that applications, forms and underwriting practices must not impose barriers to obtaining coverage or include language that discriminates against transgender persons. The department will continue to work with insurers to address rates, contract language or underwriting practices that appear discriminatory. DCBS does not expect property and casualty insurers to revise all of their forms to expressly reference the provisions of this bulletin, but will expect the insurers to correct language that is discriminatory. DCBS will not allow forms that violate state or federal law related to discrimination against transgender persons.

With health insurance, DCBS is committed to ensuring that Oregonians have access to medically necessary health care benefits, including those based on transsexualism, gender identity disorder, and gender dysphoria. DCBS believes that the Insurance Code does not distinguish between facially discriminatory policies and policies that – while facially neutral – discriminate by their operation (i.e., have a disparate impact).

A health insurer may not require a rider or special endorsement to a plan for coverage of gender dysphoria or gender-affirming treatment.

DCBS expects all health policies and health benefit plan forms to comply and in some instances may require endorsement or revision of an existing form. DCBS will continue to scrutinize rates and forms for instances of unfair discrimination on the basis of gender dysphoria or medically necessary treatments required for gender dysphoria. For example, DCBS will not allow an insurer to include provisions in contracts that violate the requirements of state and federal law as set forth in this bulletin. Nor should contracts include language in the exclusion section of the evidence of coverage that excludes medically necessary treatment for gender dysphoria.

DCBS will also continue to conduct independent reviews for denials of coverage on the basis that services are not medically necessary via the Department's external review program.

Health insurers should provide consumers with clear information about coverage of gender-affirming treatment, and expectations for medical necessity determinations related to such treatment including the appeals process for appealing a denial based on medical necessity. In order to provide clarity to consumers, health insurers should include an affirmative statement of coverage of gender-affirming services in their evidence of coverage documents.

Finally, all insurers should provide internal training for staff addressing the need to eliminate or avoid any discriminatory action against transgender persons. For health insurers, this should include written memoranda clarifying the coverage of gender-affirming treatment and coverage of gender dysphoria generally.

This bulletin takes effect immediately.

Dated this 7th day of September, 2016 at Salem, Oregon.

Laura N. Cali, FCAS, MAAA
Insurance Commissioner
Administrator, Division of Financial Regulation